

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 13 1957

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 823

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>KANSAS City</u> ³⁷⁴⁸ ₀ Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RESEARCH Hospital</u> Length of stay in lb <u>50 YEARS</u>		d. STREET ADDRESS (If outside, give location) <u>5408 BALTIMORE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>W</u> Last <u>DRAVER</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 23, 1981</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CITY WATER DEPT.</u>		11. BIRTHPLACE (City and state or country) <u>SPRINGFIELD, OHIO</u>	
13. FATHER'S NAME <u>ANDREW H. DRAVER</u>			14. MOTHER'S MAIDEN NAME <u>MOLLIE S. MORGAN</u>		

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>487-16-1240</u>	17. INFORMANT <u>MRS. RALPH L. BROWN, 4901 SUNSET DRIVE</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aortic Aneurysm - ruptured</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>None</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from <u>April - '53</u> to <u>death</u> and last saw her/him alive on <u>2-19-57</u> <input checked="" type="checkbox"/> Death occurred at <u>7:35 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>M. O. Osgood</u> (Decedent or Informant) G. M. Osgood	22b. ADDRESS <u>G. M. OSGOOD M. D. 104 P. V. MEDICAL BLDG.</u>	22c. DATE SIGNED <u>4-10-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE <u>FEB. 21, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>D. W. NEWCOMER'S SUBURBAN VILLAGE KANSAS</u>	23d. ADDRESS (City, town, or county) (State) <u>Springfield, Missouri</u>
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24. FUNERAL DIRECTOR <u>J. W. NEWCOMER'S SONS</u> ADDRESS <u>1331 R. C. Mo. BRUSH CREEK BLVD</u>	25. DATE RECD. BY LOCAL REG. <u>2-21-57</u>	26. REGISTRAR'S SIGNATURE <u>Merle Minshall</u>
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Use only standard nomenclature in Part I for the symptoms which are stated. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Raymond M. Hardy*

Licensed Embalmer No. *49*

P. O. Address *Indigo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.